Operational Policy Letter #54

Department Of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

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CHANGE IN THE DEFINITION OF AN INSTITUTION FOR PURPOSES OF ADJUSTING PAYMENTS TO RISK CONTRACTING MANAGED CARE ORGANIZATIONSC

Background and Problem:

Risk contracting health maintenance organizations and competitive medical plans (HMO/CMPs) are paid 95 percent of the standardized per capita rates of payment modified by certain demographic cost factors (AAPCCs). One of the demographic categories, *institutional status*, refers to Medicare beneficiaries who are under care or custody in institutions.

HMO/CMPs are generally paid a higher AAPCC for their Medicare enrollees who have been patients or residents of certain types of institutions for at least 30 days. In the past, HCFA has specified "nursing homes, sanatoriums, rest homes, convalescent homes, long-term care hospitals, and domiciliary homes" as the permissible types of institutions. These groupings for type of institution were used by the U.S. Census Bureau in connection with special surveys of Medicare beneficiaries performed some years ago. HCFA adopted this terminology since the AAPCC demographic cost factors for institutionalized enrollees were developed largely in part from data collected through the Census Bureau surveys.

CHPP has encountered many technical problems in using this terminology to determine when a higher AAPCC payment is justified. Generic terms such as "nursing homes" or "rest homes" can represent a wide variety of institutions. The terminology lacks specific criteria describing what is required of a facility for it to be considered a permissible institution. This has led to various interpretations by different parties. In addition, HCFA, the Office of Inspector General, and the General Accounting Office are concerned about the potential for making improper payments to HMOs and CMPs by continuing to use inexplicit terminology.

We are issuing this Operational Policy Letter to provide a clear definition regarding the type of facilities which are designated as institutions for the purpose of receiving the institutional AAPCC payment.

Definition:

To be considered institutionalized, an enrolled member must have been a resident of one of the following **title XVIII (Medicare), or title XIX (Medicaid) certified institutions for at least 30 consecutive days** immediately prior to the month for which an AAPCC payment is being made:

a) a skilled nursing facility (SNF) as defined in section 1819 (Medicare), or

b) a nursing facility (NF) as defined in section 1919 (Medicaid), or

c) an intermediate care facility for the mentally retarded (ICF/MR) as defined in section 1905(d), or

d) a psychiatric hospital or unit as defined in section 1886(d)(1)(B), or

e) a rehabilitation hospital or unit as defined in section 1886(d)(1)(B), or

f) a long-term care hospital as defined in section 1886(d)(1)(B), or

g) a hospital which has an agreement under section 1883 (a swing-bed hospital).

In an enrolled member's case who qualifies under (g), the enrolled member must be receiving post-hospital extended care services as defined in section 1883 or NF services as defined in section 1913.

Brief Explanations:

a) SNF -- An institution, or distinct part of an institution, primarily engaged in providing skilled nursing care or rehabilitative services to residents which has in effect an agreement with a hospital that ensures transfer of patients will be affected between the two whenever such transfer is medically appropriate.

b) NF -- Same explanation as SNF as described above. In addition, it includes institutions that provide health-related care and services to residents who because of their mental or physical condition require care and services which can be made available to them only through institutional facilities.

c) ICF/MR -- An institution that provides health or rehabilitative services for mentally retarded residents receiving active treatment under Medicaid.

d) Psychiatric Hospital -- An institution, or distinct part of an institution, primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

e) Rehabilitation Hospital -- An institution that serves an inpatient population of whom the vast majority require intensive rehabilitative services for the treatment of certain conditions, e.g., stroke, amputation, brain or spinal cord injuries, and neurological disorders.

f) Long-Term Care Hospital -- A hospital which has an average inpatient length of stay of greater than 25 days.

g) Swing-Bed Hospital -- A hospital which has entered into an agreement under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a SNF, would constitute extended care services.

Residency Requirement:

A Medicare enrollee must have been a resident of the above institutions for a minimum of 30 consecutive days which includes, as the 30th day, the last day of the month prior to the month for which the higher institutional rate cell is paid. This qualifying period of residency must be satisfied each month in order for the HMO/CMP to be paid at the higher institutional rate.

Temporary absences. HCFA will continue to pay the institutionalized AAPCC payment rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave if a bed in being held and paid for on behalf of the member. Temporary interruptions (less than 15 days) for medical necessity will be counted toward the 30-day requirement.

In order to clarify the residency requirement, the use of the term "calendar month" cannot be used. A calendar month can have 28 to 31 days and thus cannot be substituted for 30 days. For example, in a month with 31 days, a beneficiary would have to be institutionalized from the 2nd - 31st day of the month to meet the requirements for reporting institutionalized status.

The following examples are being provided to clarify these residency requirements:

1. A member of a risk contracting organization enters an institution identified above on March 2. On March 20, the individual is hospitalized for a surgical procedure. On April 2, the individual is discharged from the hospital, re-enters the institution, and remains there continuously through April 15. The individual does meet the residence requirement. The HMO/CMP will be paid the institutional rate for the month of April.

2. Mr X, a Medicare member (effective April 1) of a risk contracting HMO, enters one of the institutions identified above on April 15 and remains there continuously until his discharge on May 25. He does not meet the criteria for reporting institutionalized status. Although he was institutionalized for at least 30 consecutive days, it was not the 30 consecutive days which includes the last day of the month as the 30th day, as required.

His stay would have had to continue through May 31 in order to be reported for a payment adjustment for the month of June.

3. Mr Y, a Medicare member (effective April 1) of a risk contracting HMO, had entered one of the institutions identified above on February 28 and remains there continuously until his discharge on April 25. He does meet the criteria for reporting institutionalized status for April to be paid the institutional rate for the month of April. Although he was not a member of the HMO during the qualifying period of residency (March 2 through March 31), Mr. Y was institutionalized for at least 30 consecutive days which includes the last day of the month as the 30th day. (It is not required that Mr. Y be a member of the HMO during the qualifying period of residency.) Therefore, the risk contracting HMO would be paid the institutional rate for the month of April. The HMO would not be paid the institutional rate for the month of May because the qualifying period of residency (April 1 through April 30) was not satisfied.

Effective Date of Definition:

The Actuarial and Health Cost Analysis Group is updating the cost factors used to make the institutional payment adjustment. They will include only the data relevant to patients in Title XVIII (Medicare) and Title XIX (Medicaid) certified institutional facilities as outlined above. This will match the new definition of institutional facilities with the demographic cost factors used to determine payment rates. The new demographic cost factors are announced in the 45-day notice pertaining to the upcoming 1998 AAPCC's scheduled to be released on July 24. Therefore, the revised definition of which Medicare enrollees are institutionalized will be effective for all institutional payment rate adjustments made for those months beginning after December.

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